Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA RD
PASADENA TX 77504-2117

Respondent Name
IRVING ISD

Carrier's Austin Representative Box
Box Number 44

MFDR Tracking Number
M4-10-0542-01

MFDR Date Received
September 21, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier should have reimbursed Provider pursuant to section 134.403(f)(1)(A)."

Amount in Dispute: $1,520.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…Self-Insured has denied additional payment to the Provider due to improper coding for implantable being used. An implant is indicated by RC278, they are billing with an A code which is for medical supplies and incorrect. "

Response Submitted by: Harris & Harris, 5900 Southwest Parkway, Building 2, Austin, TX 78735

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 7, 2008	Outpatient Hospital Services	$1,520.16	$1,520.16

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 5, 2009
   - 222 – Charge exceeds Fee Schedule allowance
   - 785 – Items and/or service are packaged into APC rate. Therefore there is no separate APC payment.
   - 788 – Significant procedure, Multiple procedure reduction applies.

- ANSI97 – 97 – Payment is included in the allowance for another service/procedure.
- ANSIW1 – W1 – Workers Compensation State Fee Schedule Adjustment.

Explanation of benefits dated August 4, 2009

- ANSI193 – 193 – Original payment decision is being maintained. This claim was processed properly the first time.
- ANSI97 – 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- ANSIW1 – W1 – Workers Compensation State Fee Schedule Adjustment.
- ANSIW3 – W3 – Additional payment made on appeal/reconsideration.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Are the submitted code(s) valid?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables were requested however, in the position statement of the requestor, a clarifying statement was made to state “separate reimbursement for implants is not requested.”
2. Procedure code A4649 (Miscellaneous surgical supply) is valid for claim submission with additional documentation however, it is unbundled. This procedure is a component service of procedure code 23420 performed on the same date. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code J3490 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code J3490 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 23420 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0051, which, per OPPS Addendum A, has a payment rate of $2,737.89. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,642.73. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $1,612.50. The non-labor related portion is 40% of the APC rate or $1,095.16. The sum of the labor and non-labor related amounts is $2,707.66. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of

$2,707.66 divided by the sum of all S and T APC payments of $3,627.01 gives an APC payment ratio for this line of 0.746527, multiplied by the sum of all S and T line charges of $9,004.00, yields a new charge amount of $6,721.73 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.326. This ratio multiplied by the billed charge of $6,721.73 yields a cost of $2,191.28. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $2,707.66 divided by the sum of all APC payments is 74.65%. The sum of all packaged costs is $4,013.75. The allocated portion of packaged costs is $2,996.37. This amount added to the service cost yields a total cost of $5,187.65. The cost of these services exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $449.24. 50% of this amount is $224.62. The total APC payment for this line, including outlier payment, is $2,932.28. This amount multiplied by 200% yields a MAR of $5,864.56.

- Procedure code 23120 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0050, which, per OPPS Addendum A, has a payment rate of $1,859.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,115.54. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $1,095.01. The non-labor related portion is 40% of the APC rate or $743.69. The sum of the labor and non-labor related amounts is $1,838.70. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $919.35 divided by the sum of all S and T APC payments of $3,627.01 gives an APC payment ratio for this line of 0.253473, multiplied by the sum of all S and T line charges of $9,004.00, yields a new charge amount of $2,282.27 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.326. This ratio multiplied by the billed charge of $2,282.27 yields a cost of $744.02. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $919.35 divided by the sum of all APC payments is 25.35%. The sum of all packaged costs is $4,013.75. The allocated portion of packaged costs is $1,017.38. This amount added to the service cost yields a total cost of $1,761.40. The cost of these services exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $152.54. 50% of this amount is $76.27. The total APC payment for this line, including outlier payment and multiple-procedure discount, is $995.62. This amount multiplied by 200% yields a MAR of $1,991.24.
- Procedure code 99144 is unbundled. This procedure is a component service of procedure code 99205 performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment is not recommended.
- Procedure code 94762 is unbundled. This procedure is a component service of procedure code 99144 performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment is not recommended.
- Procedure code 94760 is unbundled. This procedure is a component service of procedure code 99144 performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment is not recommended.
- Procedure code 99205 is unbundled. This procedure is a component service of procedure code 23420 performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment is not recommended.
- Procedure code G0378 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

4. The total allowable reimbursement for the services in dispute is $7,855.80. The amount previously paid by the

insurance carrier is $5,720.68. The requestor is seeking additional reimbursement in the amount of $1,520.16. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,520.16.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,520.16, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		April 5, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.